STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on record review, interview and policy review, the facility failed to clarify advance directives for residents. This affected one (Resident #37) of 32 residents reviewed for advance directives. The facility census was 106. Findings include: Review of Resident #37's paper chart revealed an admitted [DATE]. The paper chart identified two separate forms for advance directives. One form indicated Resident #37 was a full code and the other form indicated Resident #37 was a Do Not Resuscitate (DNR). Both forms were dated 09/09/20. The DNR form was signed by Resident #37 on 09/09/20. Review of the electronic medical record identified Resident #37 was a full code and there was a physician order for a full code. There was no documentation the facility clarified Resident #37's advance directives. Review if the facility policy titled Advanced Directives, dated 06/01/18, stated prior to or upon admission of a resident to out facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions about medical care, including the right to formulate advanced directives should the resident indicate that he or she has issued advance directive. This deficiency substantiated Complaint Number OH00126861.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42495 Based on observation and interview, the facility failed to ensure a quiet, clean, safe, comfortable homelike environment. This affected all 53 residents of the third floor and Residents #21, #45 and #305 on the second floor. The facility census was 106. Findings include: 1. During observation on 11/03/21 at 2:45 P.M., Resident #21's room had a broken faucet in the bathroom, a hole in wall to the right of the sink, a broken switch plate cover and a granular brown substance under the sink. The trash an was full. Registered Nurse (RN) #170 verified the findings at the time of the obsrvation. During observation on 11/04/21 at 10:15 A.M. of Resident #21's room still had a broken fauct, hole in the wall, broken switch plate cover, a granular brown substance under the sink and a full trash can. During interview on 11/04/21 at 12:00 P.M., Resident #21's family member stated the sink was leaking and the toilet was clogged. The family member expressed disappointment with the cleanliness of the room as well as the toilet not being functional. 2. During interview on 11/04/21 at 9:20 A.M., Resident #45 stated his toilet was leaking and staff placed a towel around the base of the toilet to prevent water from running on the floor. Resident #45 stated his toilet had been leaking for at least two weeks. He stated staff came in 11/03/21 but did not clean bathroom. During obsrevation at the time of the interview, the wallpaper in the bathroom was loose, the light bulb over the sink did not work and the floor was sticky in both the bedroom and bathroom. During interview on 11/04/21 at 9:25 A.M., RN #170 verified the above environmental findings in Resident #45's room. During observation on 11/08/21 at 10:30 A.M., the wall paper remained loose, the light bulb over the sink still did not work and the floor was sticky. 3. During observation on 11/03/21 at 2:45 P.M., the room of Resident #305 had a missing threshold between the bathroom and room with deep dirt residue; a missing light bulb over the sink; the door handle to bathroom very loose; the sink had a crusted dirt ring around the faucet; and spilled drink residue on the wall and back of the door. During interview on 11/03/21 at 2:50 P.M., RN #170 verified the above environmental issues. Durinb observation on 11/04/21 at 10:15 A.M. and 11/08/21 at 10:30 A.M., the threshold of the door was still issing, the light bulb was missing, the door hadnle was loose, there was a dirt ring around the faucet and spilled drink residue on the wall and the back of the door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation on the 200 hallways on 11/01/21 at 11:15 A.M. revealed a heavy urine odor. On 11/04/21 at 10:00 A.M., there was a heavy urine odor. During interview on 11/04/21 at 10:00 A.M., RN #170 verified the hallway had a heavy urine odor. During interview on 11/03/21 at 3:00 P.M. Maintenance Manager (MM) #1 stated there are three housekeepers, one for each floor of the facility. Every resident room gets a basic cleaning daily and one resident room for each unit gets deep cleaned per day. One staff member for each hall should allow for each resident room to be deep cleaned once a month. If more staff were scheduled more resident concerns would be addressed regarding cleanliness of the units. The manager of the housekeeping service was to round on the units to observe any cleanliness issues, however the manager recently left employment and MM #1 was standing in for the manager until a new manager was hired. MM #1 stated he has not rounded in the morning of the facility at the time of the survey. MM #1 stated he had no complaints from residents about the cleanliness of the resident's rooms and odors on the units. 16453 5. During observation of the third floor on 11/01/21 at 9:43 A.M., the elevator door alarmed loudly when the door opened on the floor. The alarm can not be turned off until a staff person physically enters a code. During observation of the elevator on 11/02/21 at 11:37 A.M., the elevator alarm was sounding continually. The residents on the unit were yelling and screaming when the alarm was sounding. The staff stopped providing care to the resident to turn off the alarm. Five residents who were sitting in the dining room together were interviewed on 11/01/21 at 2:34 P.M. All five residents stated the alarm is awful and goes off 24 hours a day. They stated it's blaring all the time. During interview on 11/03/21 at 11:01 A.M., Resident #15 stated the elevator alarm is so loud and obnoxious and makes residents angry and lash out. Resident #15 stated the alarm goes off 24 hours a day and his room is fairly close to the elevator. Resident #15 stated if the staff are busy, the alarm can sound for a long time. 6. During observation of room [ROOM NUMBER] on 11/01/21 at 2:28 P.M., a strong urine odor was in the room that lingered into the hallway. During observation on 11/03/21 at 11:17 A.M., the floor to the room was very sticky and there was a strong urine odor remaining in the room and lingering to the hallway. 7. During observation of room [ROOM NUMBER] on 11/01/21 at 3:02 P.M., the floor was very sticky. There was a strong urine odor and a large amount of dirt and debris on the floor and around the cove molding. 8. During observation of rooms [ROOM NUMBERS] and the hallway outside of the rooms 11/04/21 at 7:05 A. M. there was a strong urine odor. State tested Nursing Assistant (STNA) #131 stated at the time of the observations the hallways always have an extremely strong urine odor. STNA #131 stated its like this all the time, because the residents have psychiatric issues. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/03/21 at 11:08 A.M., Licensed Practical Nurse (LPN) #148 confirmed the alarm for the elevator comes on every time the door opens for either side. The elevator also has a code to put into it before it can go downstairs. The first floor doors are alarm locked and alarmed. There are urine odors on the floor because some residents will not allow any one to shower them. The third floor contains mostly residents with psychiatric diagnosis. This deficiency substantiated Complaint Numbers OH00126829 and OH00126683.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42727 Based on observation, interview, record review, policy review, review of police report, and review of facility investigations, the facility failed to ensure residents were protected from abuse when actual harm was suffered by Resident #32 after Resident #105 punched Resident #32 in the face causing a laceration and a nasal fracture that required hospitalization . This affected one (Resident #32) of one resident reviewed for abuse. The facility census was 106. Findings include: 1. Review of medical record for Resident #32 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, alcohol abuse, generalized anxiety disorder, muscle weakness, tobacco use, alcohol-induced pancreatitis, schizoaffective disorder and major depressive disorder. Review of the care plan dated 04/16/21 revealed Resident #32 exhibited behavior symptoms of physical and verbal aggression towards staff and residents. Interventions included maintain a safe environment for resident, remove resident from situation, provide resident personal space, provide resident with diversional activity, administer medications as ordered, approach resident in a calm and friendly manner, identify behavior triggers, if resident becomes combative or resistive, postpone care/activity and allow resident to regain their composure, re-approach as needed and fifteen-minute checks. Review of quarterly Minimum Data Set (MDS) assessment, dated 08/23/21, revealed the resident was cognitively intact. Resident #32 did not exhibit physical or verbal behavioral symptoms. Resident #32 required supervision of one person for bed mobility, transfers, walking in room and corridor and locomotion on and off the unit. 2. Review of medical record for Resident #105 revealed an admitted [DATE] and a discharge date [DATE]. Diagnoses included major depressive disorder, acute duodenal ulcer with hemorrhage, anemia, alcohol dependence, gastrointestinal hemorrhage, acute and chronic respiratory failure with hypoxia, laparoscopic surgical procedure converted to open procedure, encounter for surgical aftercare following surgery on the digestive system and hypovolemic shock. Review of the quarterly MDS assessment, dated 10/01/21, revealed Resident #105 was cognitively intact. Resident #105 did not exhibit any hallucinations or delusions. Resident #105 exhibited physical behavioral symptoms directed towards others on four to six days. Resident #105 did not exhibit verbal behavioral symptoms directed towards others, or other behavioral symptoms not directed towards others. Resident #105 did not reject care or exhibit wandering. Resident #105 required limited assistance of one person for bed mobility, transfers, supervision with set up for walking in room and corridor, locomotion on and off unit, dressing, eating, personal hygiene, and bathing and supervision with one person physical assistance for toilet use. Resident #105 received seven days of an antidepressant. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of a facility Self Reported Incident (SRI), dated 09/12/21, revealed an altercation related to physical abuse, emotional and verbal abuse involving Residents #32 and #105. Resident #32 and #105 were alleged to have been arguing and Resident #105 swung his open hand around Maintenance Assistant #102 making minimal contact to Resident #32's face. Review of the facility's SRI, dated 09/27/21 with a discovery date of 09/26/21, stated at 3:45 P.M. the incident occurred at the facility's designated smoking area. Narrative summary of the incident and investigation revealed staff and resident statements indicated during the scheduled smoking time the resident-to-resident incident occurred. The actual start of the altercation was not witnessed by staff. Resident interviews indicate Resident #32 entered the smoking area and began raising his voice and going toward Resident #105 with his hand drawn like he was going to hit him. Resident #105 jumped up and Resident #105 and Resident #32 began swinging at each other. Resident #28 fell during this time and was unable to recall what made her fall. Staff intervened and separated residents while another staff member contacted 911. Resident #105 was placed on one-on-one supervision. Resident #28 and Resident #32 were transferred to the emergency room (ER) for evaluation. Resident #105 remained on one-on-one supervision while Social Services worked on the discharge plan with the resident. Resident #105 was seen by a psychosocial provider for services and medication adjustment. Resident #105 had alternative smoke breaks with one-on-one employee supervision and the breaks were independent of other residents. Upon return from the hospital, Resident #32 was placed on one-on-one supervision and moved to a different unit. The facility was working with the responsible party on alternate placement for Resident #105. The facility's plan included psychosocial needs will be monitored for other residents witnessed or involved in the incident. The facility reported they completed re-education with staff regarding behavior management and education with each resident with a brief interview for mental status score of thirteen or higher regarding resident-to-resident altercations. The facility further reported they were committed to protecting their residents from abuse which included other residents. Facility reported law enforcement was involved and the officer reported from resident interviews, Resident #32 initiated the altercation. Neither resident was detained by the police. Review of police report dated 09/26/21 at 4:05 P.M. revealed the reporting officer was dispatched to the facility for a report of a fight. There was no mention of a weapon. Upon arrival, the reporting officer made contact with Resident #32 who stated that Resident #105 assaulted him. Resident #32 stated he was outside smoking a cigarette when Resident #105 walked up to him and punched him for no reason. Resident #105 stated that he was outside about to smoke a cigarette when Resident #32 walked up to him a cocked his fist back like he was going to punch him. Resident #105 stated that he defended himself and punched Resident #32 four times in self-defense. Resident #28 and Resident #34, who were witnesses, corroborated Resident #105's version of events. While the reporting officer was speaking with Resident #28, she informed him that Resident #32 walked up to Resident #105 and swung first. After hearing this, Resident #32 stated that he was not trying to punch Resident #105 and that he was trying to punch Resident #105's friend. Resident #28 was transported to the hospital in stable condition for precautionary reasons as she was knocked down while Resident #32 and Resident #105 were fighting. Resident #32 was transported to the hospital in stable condition to be treated for a laceration below his left eye. Review of facility investigation revealed resident and staff interviews were conducted on 10/01/21. Resident #100 reported Resident #32 was accusing Resident #105 of stealing cigarettes and after three times of him accusing Resident #105, Resident #32 and #105 got into it. Resident #32 was accusing Resident #100 of the same thing last week. Resident #100 reported he just ignored him and walked away. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #4 reported Resident #105 was hitting Resident #32. Resident #86 reported Resident #32 walked over and swung at the other guy. Resident #105 reported he and Resident #28 were sitting by the tree, Resident #32 came over, swinging at him so he stood up and protected himself and punched him back. Resident #28 reported she and Resident #105 were sitting down getting ready to smoke a cigarette, Resident #32 came over to Resident #105 and leaned down in Resident #105's face yelling with his hand drawn like he was going to hit Resident #105. Resident #105 jumped up and they both started swinging. State tested Nursing Assistant (STNA) #179 reported she heard someone screaming for help. STNA #179 ran to the smoking area. STNA #147 told her they were fighting. STNA #179 reported she saw Resident #105 on top of Resident #32, hitting him. STNA #179 reported she pulled Resident #105 off of Resident #32. Resident #28 was lying on the ground. Resident #105 stayed behind him. STNA #179 reported she had Resident #32 lay still and called 911. STNA #147 came back outside. STNA #179 reported she took Resident #105 with her, and he stayed in the chair in the lobby away from everyone. Police came and spoke to Resident #105. Emergency Medical Services (EMS) arrived, assessed Resident #32 and Resident #28, and took them to the hospital. Review of an assessment titled, eInteract Transfer Form V5, dated 09/26/21, revealed Resident #32 was sent to the hospital for a trauma injury to the face on 09/26/21 at 3:45 P.M. Review of hospital imaging report with a date of service of 09/26/21 revealed a computed tomography (CT) scan of the face for trauma and indicated assault. Imaging revealed bilateral displaced fractures of the nasal bone near the nasal maxillary sutures with the right-sided deviation of the fracture fragments. There was extensive overlying soft tissue swelling and severe s-shaped configuration of nasal septum with possible fracture of the anterior osseous part of the nasal septum. There were extensive soft tissue swelling and hematoma within the subcutaneous tissues of the left malar region. Review of hospital imaging report with a date of service 09/26/21 revealed a CT of the head for trauma and indicated assault. There were bilateral, displaced nasal bone fractures and prominent soft tissue hematomas involving the left frontal scalp as well as the left face. Maxillofacial CT is being performed for further evaluation. Review of hospital after visit summary dated 09/26/21 through 10/02/21 revealed the mechanism of injury was assault with extensive soft tissue swelling, bilateral nasal bone fractures, nasal septum fracture, left elbow laceration and left subconjunctival hemorrhage with repair left facial laceration and closed nasal reduction. Resident #32 had a left eyebrow laceration repair on 09/26/21 and a closed nasal reduction and repair of facial laceration on 09/29/21. Discharge planning included trauma clinic follow up, plastic surgery follow up in one week on 10/06/21, outpatient follow up with mental health provider of choice and outpatient follow up with primary care provider. Review of medication administration record (MAR) revealed Resident #105 was placed on one-on-one every shift for safety with a start date 09/27/21 and was continued through Resident #105's discharge on 10/07/21. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of assessment titled Nursing Admission/Readmission Evaluation, dated 10/02/21, revealed facial injuries. The assessment indicated Resident #32 had scattered bruises, extensive soft tissue swelling with bilateral nasal bone fractures and nasal septum fracture, left eyebrow laceration and left subconjunctival hemorrhage. Review of nurse practitioner progress note dated 10/08/21 at 4:00 P.M. revealed bruises all over face, injury from altercation with another resident and monitor for pain. Review of the weekly nursing summaries, dated 10/11/21, 10/18/21, 10/25/21 and 11/01/21 revealed Resident #32 had bruising to the face. Observation on 11/01/21 at 12:21 P.M. of Resident #32 revealed bruising and one scab on the left cheek, a cut with a scab, one scab on the bridge of the nose and three scabs above the left eyebrow. During interview on 11/01/21 at 12:21 P.M. with Resident #32 revealed another resident had a weapon, the metal knuckle device. The unidentified resident hit Resident #32 in the face. Resident #32 did not know the name of the resident who hit him and reported the resident was a lot younger than Resident #32. Resident #32 revealed the incident happened in September 2021 in the smoking area. Resident #32 reported the resident hit Resident #32 four to five times to the left-hand side of his eye, nose and cheek area. During interview on 11/03/21 at 5:55 P.M., the Director of Nursing (DON) stated Resident #155 pushed the door to go outside to the smoke area and all the resident flooded out. Resident #28 and Resident #105 went outside and sat down. The STNA have to make sure the smoke cart is locked up. Resident #32 came out and immediately started yelling at Resident #105 and raising his fist and struck Resident #105 making contact. The DON reported Resident #105 did not have any injury. Resident #32 was frail and had a lot of talk. Resident #105 was short, stout and healthier. Another resident yelled that they were fighting, then STNA #147 ran out and saw they were on the ground. STNA #147 ran for help. The receptionist at the time, STNA #179, ran to them and separated them and then called 911. She had Resident #105 behind her. Resident #32 attempted to get up and she told him to stay down until the EMT and police came. STNA #179 then took Resident #105 with her one-on-one and the facility got him discharged . Resident #32 sustained fractures to the nose and the left orbital eyebrow according to Resident #32's sister who verbally told the DON. The DON reported it all happened in less than 30 seconds, approximately, and was not otherwise unsupervised as it was very quick while STNA #147 was locking up the smoking supply cart. The smoking supply cart was just inside the door to the room where they keep the cart. Resident #28 did not sustain any injuries. Resident #105 was one-on-one supervision until he discharged . When Resident #32 was readmitted , he was put on fifteen-minute checks and his room was moved to the second floor to keep them separated and reduce any interaction as much as possible. The DON confirmed Resident #32 was no longer on fifteen-minute checks. Resident #32 verbally antagonizes people and Resident #32 sees psychiatry services frequently. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During interview on 11/17/21 at 12:39 P.M., STNA #147 revealed she was familiar with Resident #32 and #105 and she was familiar with the resident-to-resident altercation that occurred in the smoking area on 09/26/21 between Resident #32 and #105. STNA #147 revealed the altercation occurred during the smoke time and estimated it was around 4:00 P.M. or 5:00 P.M. STNA #147 reported she had already locked up the smoking cart and was outside with the residents lighting their cigarettes. STNA #147 denied knowledge of which specific resident she was lighting cigarettes for. STNA #147 revealed she heard residents saying stuff and she turned around to see Resident #105 hitting Resident #32 in the face. STNA #147 reported it all happened so fast. STNA #147 revealed she went to get help and called out, Help! Help! They're fighting. Get the nurse! Get the nurse! and she went back outside with the residents. STNA #147 reported again that it all happened so fast, and could not estimate a time other than under a minute that she went to get help. STNA #147 revealed she did not walk up to the receptionist desk, but called out from the hallway. STNA #147 reported she and a secretary, whom she did not recall the name and no longer works at the facility (STNA #179), broke up the fight. STNA #147 denied ever having seen Resident #32 and #105 in a verbal or physical altercation prior to this. STNA #147 confirmed she had completed a witness statement regarding this incident. STNA #147 confirmed residents are supervised during smoke times. Review of facility policy titled Abuse Prevention Program, revised March 2021, revealed our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment and involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptom. Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to our residents, family members, resident representative, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Procedures included identification of occurrences and patterns of potential mistreatment/abuse. This deficiency substantiates Complaint Numbers OH00126683 and OH00126829.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on observation, record review, interview and policy review, the facility failed to provide personal hygiene including showers, shaving and nail care to residents who need assistance. This affected five (Residents #28, #33, #39, #63 and #78) of eight residents reviewed for assistance with activitis of daily living. The census was 106. Findings include: 1. Record Review revealed Resident #33 was admitted on [DATE]. Diagnoses included multiple sclerosis, dementia, and dysphasia. Review of the quarterly Minimum Data Set (MDS) assessment revealed Resident #33was cognitively intact and was totally dependent on staff for all activities of daily living. Resident #33 had limitations on range of motion of both of upper extremities. During observation on 11/01/21 at 9:52 A.M., Resident #33 had contractures of both arms and hands. The resident's fingernails on both hands were very long and were pressed against her skin on her palms, due to the contractures. Resident #33 was asked when the last time her nails were cut and she stated a long time ago. Resident #33 also had a large amount of black hair on her chin and very long toe nails. During interview on 11/03/21 at 7:20 A.M. Resident #33 stated she actually got a shower yesterday; however no one cut her fingernails toenails and or shaved her chin. During interview on 11/03/21 at 9:44 A.M., the Director of Nursing (DON) confirmed Resident #33 needed her fingernails and toenails cut and chin hair shaved. 35035 2. Record review revealed Resident #39 was admitted to the facility on [DATE]. Diagnoses included diabetes type two, ischemic attack, heart disease, chronic kidney disease, congestive heart failure, left humerus fracture. Review of Resident #39's comprehensive MDS assessment, dated 08/28/21, revealed the resident had intact cognition, was a two person assist with activities of daily living (ADL) and required the assistance of two persons with bathing and personal hygeine. Review of Resident #39's care plans, dated March 2021, revealed a focus for assistance with ADL's related to medical conditions including broken humerus, diabetes, chronic kidney disease, and falls. Interventions for the focus include staff to assist with showers on Tuesdays and Fridays during the day shift. Review of Resident #39's task worksheet for bathing and showers dated from 10/12/21 to 11/05/21 revealed the resident received only three showers on 10/12/21, 10/19/21, and 10/26/21, out of eight showers scheduled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #39's progress notes dated from March 2021 to November 2021 revealed there was no documentation of the resident refusing care. There was no documentation of baths being given instead of showers on the scheduled shower days. During interview on 11/02/21 at 11:30 A.M, Resident #39 stated she would prefer showers to bed baths especially now because the wounds on her heels have healed. Resident #39 stated she has requested her showers be done during the day shift in the morning but stated she understood there is not enough staff to get her showers on a regular basis. Resident #39 stated she has gone weeks without a shower and no longer is receiving bed baths on a regular basis. Resident #39 stated she has reported the missed showers to the nurses but there has been no improvement. Resident #39 stated she is not offered another shower on another day when her shower is missed on her scheduled days. During interview on 11/03/21 at 5:05 P.M., Registered Nurse (RN) #170 revealed aides are to give showers on day shift and night shift per resident request. There are residents who refuse showers however if they refuse, the aides are to notify the nurses and offer showers on another day. RN #170 stated there have been reports from residents regarding missed showers. During iterview on 11/04/21 at 11:00 A.M., the DON stated staff are to document showers and hygiene in the resident's bathing task in the electronic record. The DON verified Resident #39 has had missed showers per her medical records. 3. Record review reveald Resident #78 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction due to embolism, acquired absence of left leg, right leg, right arm and left arm, heart failure, hemiplegia, and alcohol abuse. Review of the comprehensive MDS, dated [DATE], revealed the resident had intact cognition and required the assistance of two persons for ADL's. Review of Resident #78's care plans, dated November 2018, revealed a focus for ADL self-care deficit and limited physical mobility related to left side hemiplegia, weakness, bilateral lower arm amputee and bilateral lower leg amputee. Interventions for the focus include the resident requires total assistance by one staff with all personal hygiene needs. Review of Resident #78's task worksheet dated from 10/14/21 to 10/28/21 the resident received three showers, on 10/14/21, 10/21/21 and 10/28/21. On 10/25/21 the resident was documented as completely independent for showers. Review of Resident #78's shower sheets dated from March 2021 to October 2021 revealed the resident received six showers and had one refusal. Review of Resident #78's progress notes dated from February 2021 to October 2021 revealed no documentation of resident refusals of showers or baths. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/01/21 at 2:25 P.M. , Resident #78 stated he has not been offered or received all his showers or baths. Resident #78 stated he was a full assist for his bathing. Resident #78 stated the staff do not offer any type of bathing on most days. Resident #78 said he could not bathe himself due to his amputations. Resident #78 stated he has reported his missed showers and baths and has requested bathing be done on different days or shifts when his bathing is missed on his scheduled days. During interview on 11/04/21 at 11:00 A.M., the DON revealed staff are to document showers and hygiene in the resident's bathing task in the electronic record. The DON verified Resident #78 is not able to be independent due to his medical comorbidities and amputee status. Staff should not be documenting the resident is able to complete his ADL care independently. The DON verified the missing showers in the medical record. 41266 4. Review of Resident #28's medical record revealed an admitted on 06/25/20. Medical diagnoses included asthma, major depressive disorder, dementia without behavioral disturbance, anxiety disorder, repeated falls, and polyneuropathy. Review of the quarterly MDS assessment for Resident #28 revealed the resident had mildly impaired cognition. The resident displayed mild depression. There were no behaviors indicated on the assessment. The resident required limited assistance from one staff to assist with bed mobility and transfers and supervision from one staff for personal hygiene, toileting and dressing. The resident required physical help from one staff for bathing. The resident was not steady but was able to stabilize herself without assistance from staff. The resident used a walker for assistance with ambulation. Review of nursing notes from 07/01/21 through present revealed no indication Resident #28 had refused showers or bed baths. Review of the plan of care for Resident #28 dated 06/25/20 revealed the resident needed assistance with ADL's due to generalized weakness and a history of falls. Interventions included education of asking staff for assistance during shower, resident was able to shower with supervision to limited staff assistance every shift and as needed, resident was to receive a bath or shower every Sunday and Wednesday during day shift. Documentation was required. Review of the bathing and shower task for the last 30 days revealed no showers or bed baths were documented for Resident #28. Observations of Resident #28 from 11/01/21 through 11/03/21 at various times revealed the resident was dressed in a hospital gown with hair disheveled and appeared uncombed and unwashed. No body odor was detected. During interview on 11/01/21 at 2:39 P.M., Resident #28 stated she was not receiving showers or bed baths as scheduled. The resident stated she had not been showered or bathed in one to two weeks. During interview on 11/04/21 at 11:03 A.M., Resident #28 revealed she did receive a bed bath this morning but did not get her hair washed or combed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 11/03/21 at 4:12 P.M., Licensed Practical Nurse (LPN) #106 revealed Resident #28 rarely refused showers or bed baths. The resident was not usually resistive to care. During interview on 11/04/21 at 11:13 A.M. , the DON confirmed there were no shower sheets or documentation of Resident #28's showers or bed baths for the months of September or October. 5. Review of Resident #63's medical record revealed an admitted on 12/20/19. Medical diagnoses included cerebellar stroke syndrome, Bipolar Disorder, cerebral infarction (stroke), major depressive disorder recurrent, and schizoaffective disorder-bipolar disorder. Review of the quarterly MDS assessment dated [DATE] revealed the resident had mildly impaired cognition. The resident had moderate depression. No behaviors were indicated on the assessment. The resident required extensive assistance from one to two staff to complete ADL's. The resident was totally dependent on staff for bathing. Review of the nurse's notes dated from 07/01/21 to current revealed no indication the resident had refused showers or bed baths. Review of Resident #63's plan of care dated 12/21/19 revealed the resident needed assistance with activities of daily living due to activity intolerance, hemiplegia, schizoaffective-Bipolar disorder and morbid (severe) obesity. Interventions included the resident was dependent on one staff to provide a bath or shower, resident was to receive a bath or shower every Tuesday and Saturday during day shift and documentation was required. Review of the shower and bathing task for the last 30 days revealed no showers or bed baths were documented as provided for Resident #63. During observation of Resident #63 from 11/01/21 through 11/03/21 at various times revealed the resident was dressed in a hospital gown with hair disheveled and appeared uncombed and unwashed. No body odor was detected. During interview on 11/01/21 at 4:52 P.M., Resident #63 stated she had received a bed bath yesterday but did not have her hair washed or combed. Prior to yesterday, the resident had not been bathed or showered in over a week. The resident stated she should receive showers on Tuesdays and Saturdays. The resident reported having obsessive compulsive disorder (OCD) and did not like to feel dirty. During interview on 11/02/21 at 6:00 P.M., Resident #63 stated she had not received a shower or a bed bath. During interview via telephone on 11/03/21 at 10:54 A.M. with Resident #63's family member, there was a concern that Resident #63 was not bathed or showered when scheduled. The resident's family member stated the resident would not refuse to be bathed or showered because she did not like to be dirty. During interview on 11/04/21 at 11:13 A.M., the DON confirmed there were no shower sheets or documentation of showers or bed baths for Resident #63 for the months of September or October. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Activities of Daily Living (ADL's), Supporting, revised March 2018, revealed the policy stated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Furthermore, appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care). This deficiency substantiated Complaint Numbers OH000126898, OH00126829, OH00126683 and OH00127346.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on observation, record review and interview, the facility failed to ensure a resident received services for limited range of motion (ROM) to prevent further decrease in ROM. This affected one (Resident #33) of two residents reviewed for ROM. The facility census was 106. Findings include: Record review revealed Resident #33 was admitted on [DATE]. Diagnoses included multiple scleroses, dementia, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment identified Resident #33 was cognitively intact and was totally dependent on staff for all activities of daily living. Resident #33 had limitations on range of motion of both side of upper extremities. Review of Resident #33's written plans of care identified no interventions for her limited range of motion and contractures to the hands. Review of Resident #33's physician orders stated staff were to apply bilateral upper extremity elbow and hand splints daily as tolerated. Restorative to apply and remove. Nursing to monitor skin every day for redness, irritation or breakdown. During interview on 11/01/21 at 10:14 A.M., Resident #33 stated the staff did not do range of motion on her hands. Resident #33 stated she did have splints at one time but does not even know if they are in her room. During observation at the time, Resident #33 had contractures of the hands. During observation on 11/3/21 at 7:20 A.M. and 11/04/21 at 7:14 A.M., Resident #33 did not have any splints in place to her hands or elbows. The splints were not seen in the resident's room. During interview on 11/3/21 at 9:48 A.M., the Director of Nursing (DON) confirmed Resident #33 has and order for splints and they have not been applied. The DON stated there was no evidence any range of motion was being completed and she was unaware of where Resident #33's splints are located. This deficiency substantiated Complaint Number OH00127346.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on record review and interview, the facility failed to provide adequate supervision to prevent a fall without injury. This affected one (Resident #33) of four residents reviewed for falls. The facility census was 106. Findings include: Record review revealed Resident #33 was admitted to the facility on [DATE]. Diagnoses included multiple scleroses, dementia, and dysphagia. Review of the quarterly Minimum Data Set (MDS) assessment identified Resident #33 was cognitively intact and totally dependent on staff for all activities of daily living. The resident had limitations on range of motion of both side of upper extremities. The care area assessment dated [DATE] documented the resident was not ambulatory with severe impairment to generalized body, she can only move her hands and head slightly. The record identified special instructions that the resident was a two person assist at all times. During interview on 11/01/21 at 9:52 A.M., Resident #33 stated she fell out of a shower bed a few weeks ago. She stated State tested Nursing Assistant (STNA) #175 was alone in the shower room with her and she is supposed to have two staff persons to shower her. The resident stated she was not injured however they did complete X-rays to make sure. Review of the nursing progress notes revealed no documentation regarding the fall. Nursing notes dated 09/28/21 at 3:38 P.M. documented the resident's family and physician were notified of negative X-ray results. Review of the facility documented titled Witnessed Fall Report, dated 09/28/21 at 12:00 P.M., documented STNA #175 came out of the shower room and was yelling for help. An unidentified nurse and STNA went into the shower room and found Resident #33 laying on the shower room floor on her stomach and leaning toward her right side. STNA #175 stated she was turning Resident #33 toward her left side to rinse her back and the pin on the shower rail broke. The shower bed was examined on 11/04/21 at 7:23 A.M. The shower bed was constructed of PVC pipe and does have full rails on either side. The rails come up from the side and there are pins to lock the side rails into place. During telephone interview on 11/04/21 at 9:26 A.M., STNA #175 stated she was alone with Resident #33 in the shower room. She went to turn her and she slid out of the shower bed onto the floor. STNA #175 stated the facility was short of staff that day and she did not have another STNA to assist her. This deficiency substantiated Complaint Numbers OH00126683, OH00127107 and OH00127346.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16453 Based on record review and interview, the failed to ensure a resident was not receiving unnecessary medications. This affected one (Resident #37) of six sampled residents reviewed for medications. The facility census was 106. Findings include: Review of Resident #37's medical record revealed an admitted [DATE], following a extensive hospitalization for treatment of COVID-19. The record revealed Resident #37 was in the hospital from 08/20/20 through 09/20/21. Observation of Resident #37 from 11/01/21 through 11/04/21, revealed Resident #37 resided in a four bed ward with three other residents. The resident was not provided with a privacy curtain that could extend around his bed to provide full visual privacy. Resident #37 was observed to rarely leave his room and is dependent on staff to get up. Review of Resident #37's progress notes dated 01/01/21 a 4:43 P.M., document Resident #37 is having a sexual behavior. He pulls his blanket down and start masturbating whenever any staff member entered his room. Supervisor on floor and Certified Nurse Practitioner (CNP) are aware. Review of Resident #37's medication regimen revealed Tagamet (cimetidine) was started on 01/01/21 for disorders of the male genital organs. Tagamet is an H2 receptor which blocks androgen receptors in the pituitary reducing sexual desire in individuals of both sexes and affecting arousal and orgasm. Common potential side affects include; agitation, depression and drowsiness. Resident #37 was started on Tagamet 200 milligram (mg) on 01/01/21, then 200 mg twice a day. On 10/27/21, the dosage was increased to 400 mg twice a day. Review of Resident #37's psychiatric progress notes dated 09/24/21 at 11:20 A.M., revealed Resident #37 has no previous psychiatry history. Resident #37 was admitted on [DATE] for skilled rehabilitation. Resident #37 was seen today with a sheet over him. The resident is subdued and apathetic. The resident refuses weights and will throw dinner trays. Review of Resident #37's behavior plan of care stated he will masturbate when staff is speaking with him in his room; will remove all clothing and lay in bed naked. The plan of care revealed no plan to provide Resident #37 privacy for the sexual acts and or evidence Resident #37 was completing the sexual acts in an inappropriate location. The records identified no alternative interventions prior to the start of the Tagamet. Review of the medical record for Resident #37 identified no evidence of any reason for the increased dosage of the Tagamet on 10/27/21. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/03/21 at 9:44 A.M., the Administrator and Director of Nursing stated Resident #37 was started on Tagamet on 01/01/21 and the dosage increased on 10/27/21. Both staff stated there was no evidence of any sexual issues with Resident #37, except for masturbating in his own room on 01/01/21. Both confirmed there no other interventions attempted prior to prescribing Resident #37 the Tagamet medication. This deficiency substantiates Complaint Number OH00126861.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42727 Based on observation, interview, and policy review the facility failed to ensure unit refrigerators and freezers had thermometers and logs were maintained for tracking temperatures on the second floor unit two. Additionally, the facility failed to ensure dirty dishware was removed from resident rooms and the third-floor unit three nourishment room food preparation area. This affected one random resident (Resident #65) related to removal of dirty dishware from resident rooms and had the potential to affect all 106 residents who consumed food in the facility. The facility census was 106. Findings include: 1. Observation on 11/01/21 at 5:28 P.M. revealed the second-floor unit two nourishment room revealed the refrigerator and the freezer did not contain a thermometer in the refrigerator and the freezer. There were no respective logs observed for temperature monitoring. Observation on 11/02/21 at 10:56 A.M. of the second-floor unit two nourishment room revealed no thermometer was located in the refrigerator and the freezer and no temperature monitoring logs were in the room. Licensed Practical Nurse (LPN) #148 checked the refrigerator, the freezer and looked around in the room for the logs and thermometers. Interview on 11/02/21 at 10:56 A.M., the LPN #148 verified there were no thermometers in the second-floor unit two nourishment room refrigerator and freezer. LPN #148 verified there were no temperature monitoring logs for the refrigerator or freezer anywhere in the room. Interview on 11/04/21 at 1:45 P.M., the Manager of Nutritional Services #103 revealed no evidence of temperature monitoring logs for 11/2021 for the unit two refrigerator and freezer. Discussed no temperature monitoring logs and no thermometers in the unit two refrigerator and freezer on 11/01/21 and 11/02/21. Manager of Nutritional Services #103 provided evidence of temperature monitoring logs for the unit two refrigerator and freezer for 10/2021. No logs were provided for 11/2021. Review of facility policy titled Equipment Temperature Monitoring dated 10/2018 revealed the purpose was to monitor the temperatures of refrigeration/freezer equipment to ensure proper operation. Temperatures of refrigeration/freezer equipment will be monitored twice per day. Guidelines included each refrigerator/freezer unit will have an internal thermometer. Thermometers in each location will be checked twice daily and recorded on the equipment monitoring log. Equipment identified as not holding food within the safe food holding temperature range will be indicated as do not use until appropriate repairs are made. All foods will be removed from the unit and stored in other units until the repair is complete. 2. Interview on 11/04/21 at 10:34 A.M. with Cook #123 revealed she has been working here for [AGE] years. Cook #123 reported sometimes some meal trays do not get picked up until the next meal. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 11/04/21 at 1:24 PM with Manager of Nutritional Services #103 and LPN #109 revealed Resident #65 yelling out and wanting someone to take his tray. LPN #109 removed the meal tray from the room of Resident #65. Observed LPN #109 with the dirty tray containing a maroon dome lid with a few pieces of food particles with no other food items or drinks on the tray. After the removal of the dirty tray and delivery of the lunch tray, Resident #65 then yelled out again and gave his lunch plate to the Manager of Nutritional Services #103. Interview on 11/04/21 at 1:24 P.M. with Manager of Nutritional Services #103 and LPN #109 verified the cleared tray was from the room of Resident #65. LPN #109 revealed she was just helping out and she did not know if this tray was from breakfast, or how long it had been there. 3. Observation on 11/04/21 at 1:34 P.M. revealed the third-floor unit three nourishment room with partially consumed foods, beverages and an array of dirty dishware and dirty trays. Observed Resident #155's breakfast tray ticket and beverages including milk, juice and toast. Observed random Styrofoam, an additional plate from lunch and a second tray with toast, sausage, hard boiled eggs, milk, and oatmeal. The items were covering both sides of the countertop surrounding the microwave and on the top of the microwave used to heat resident foods. The unit three ice machine, refrigerator and freezer were observed in this room. Interview on 11/04/21 at 1:34 P.M. with Manager of Nutritional Services #103 verified the third-floor unit three nourishment room with partially consumed foods, beverages and an array of dirty dishware and dirty trays. Verified Resident #155's breakfast tray ticket and beverages including milk, juice, toast. Verified a random Styrofoam, a second tray with toast, sausage, hard boiled eggs, milk, and oatmeal and the additional plate from lunch covering both sides of the countertop surrounding the microwave and on the top of the microwave used to heat resident foods. Review of facility policy titled Resident Personal Food Policy dated 06/2018 revealed food brought in to the facility for resident consumption by outside sources shall be stored in nourishment room refrigerators or in resident room refrigerators. Microwaves will be available for reheating of foods. A copy of this policy will be reviewed and provided to the resident/representative on admission to the facility. This policy will be available for review in various areas of the facility as a reference for visitors and staff. Review of facility policy titled Food Storage dated 10/2018 revealed food will be stored in a manner consistent with Food Code Guidelines and protected from contamination. Review of facility policy titled Food Production dated 03/2019 revealed food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and be free of injurious organisms and substances. Procedures included the kitchen will be kept clean, neat and orderly and equipment will be kept clean. Handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces with which food or drink will come in contact. Foods that have stood for several hours at room temperature cannot be considered safe and free from contamination and cannot be made so by refrigeration, they must be discarded. Review of facility policy titled Infection Control dated 03/2019 revealed the Dietary Manager will be responsible for overseeing the provision of safe food to all residents. Procedures included good sanitary food handling practices with sanitary conditions maintained in the storage, preparation and serving areas will be carried out at all times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of Columbus LLC	44 S Souder Ave Columbus, OH 43222

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This deficiency substantiates Complaint Number OH00126683.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365754	A. Building B. Wing	11/16/2021

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 16453 Based on quality improvement activities, facility survey history reports and staff interviews, the facility failed to complete an approved quality improvement project for the past year and correct quality deficiencies. This has the potential to affect all 106 residents residing in the facility. Findings include: Review of the facility's prior survey history profile was completed on 11/01/21. The profile identified the facility had been cited for F-677 (lack of ADL care for dependent residents) on annual surveys of April 2018, January 2019 and January 2020. The facility has been cited for F-600 for (failing to prevent abuse) on previous annual surveys of January 2019 and January 2020. The facility has also been cited for F-812 for (food storage issues) on previous annual surveys of January 2019 and January 2020. Review of the facility's complaint investigations conducted since January 2021 identified the facility was cited for medication error rates greater than five percent on 06/22/21 and 04/12/21. Review of the facility quality assurance and improvement plans provided no evidence the facility conducted an approved quality improvement project in the past year. During interview on 11/08/21 a 11:42 A.M., the Administrator and Director of Nursing stated the facility was monitoring citation corrections for about four weeks after their plan of correction was approved however there was no continual ongoing monitoring to ensure the citations remained corrected, because as soon as they get past one survey they had another complaint investigation. The interview confirmed the facility has not been completing ongoing monitoring and verified the lack of a quality improvement project for the past year. This deficiency substantiates Complaint Number OH00126683.